

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850



September 30, 2026

Laura Phelan
Administrator, Division of Medical Programs
Illinois Department of Healthcare and Family Services
201 South Grand Ave. East
3rd Floor
Springfield, IL 62763-0001

Dear Administrator Phelan:

The Centers for Medicare & Medicaid Services (CMS) is approving Illinois' request to renew its section 1115 demonstration entitled, "Continuity of Care and Administrative Simplification" (Project Number 11-W-00341/5), in accordance with section 1115(a) of the Social Security Act (the Act). With this approval, the demonstration renewal will be effective October 1, 2026 through September 30, 2031, upon which date, unless renewed or otherwise temporarily extended, all authorities granted to operate this demonstration will expire.

CMS has determined that the demonstration is likely to assist in promoting the objectives of the Medicaid statute by promoting continuity of care among Medicaid beneficiaries and simplifying the state's administrative procedures. This approval will continue the authorities from the previous demonstration with the exception of authorities that have moved to the Medicaid state plan, as described in more detail below.

CMS's approval of this section 1115(a) demonstration is subject to the limitations specified in the attached waiver authority, expenditure authority, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as waived or not applicable to expenditures under the demonstration.

Program Integrity

States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid funds and must fully comply with all applicable Medicaid statutes and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in title XIX of the Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity including processes to identify, investigate, and refer suspected fraud, and methods to receive complaints and identify

questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid services, including referrals to law enforcement when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

Extent and Scope of the Demonstration Renewal

With the approval of this demonstration renewal request, the state continues to automatically re-enroll a beneficiary into the same managed care organization (MCO) in which they were enrolled when they lost eligibility if the beneficiary's coverage was terminated due to failure to complete the renewal process and the beneficiary submits his/her redetermination paperwork within 90 days after termination. Approximately 80 percent of Medicaid enrollees in Illinois are in managed care. Renewal of this authority ensures that enrollees will be able to remain in the same Medicaid MCO, and it will reduce churn between MCOs and FFS. If CMS did not renew the current section 1115 demonstration managed care expenditure authority, beneficiaries submitting redetermination paperwork after 60 days will be moved to fee for service (FFS).

The state is also requesting time-limited authority for the continuation of the waiver of HPE through December 31, 2028. The state requested this authority during the previous demonstration period to promote the continuity of care and managed care coverage that comes with a full Medicaid application. The state had expected to phase out this authority during the next demonstration period, but given additional challenges from COVID, subsequent COVID unwinding, as well as the additional operational impacts from requirements in the Working Family Tax Cut (WFTC) legislation, the state requested additional time to waive HPE. This time-limited authority will allow the state to implement changes from the WFTC legislation and make sure it is properly prepared for the implementation of HPE, allowing the state to engage stakeholders in the development of HPE policies and establishing hospital performance standards. Illinois affirmed it has a project management plan in place to ensure implementation of HPE by January 1, 2029.

On April 12, 2021, the demonstration was amended to allow the state to provide 12 months of Medicaid benefits to postpartum women. The state never implemented the demonstration authority for postpartum benefits because it was given the option to do this through its state plan. As of July 1, 2022, the state began using its state plan amendment for this authority. As a result, per the state's request, the expenditure authority for postpartum benefits has been removed from the demonstration.

Request Withdrawn by the State

The state withdrew its request on March 17, 2026 for demonstration authority to accept out-of-state address changes as reliable from the United States Postal Service National Change of Address database and Medicaid MCOs.

Budget Neutrality

This demonstration project is being renewed using CMS’s current approach to determining budget neutrality as described in CMS State Medicaid Director Letter (SMDL) #24-003.¹ However, CMS acknowledges that section 71118 of WFTC legislation adds a new subsection (g) to section 1115 of the Act with budget neutrality requirements that will apply beginning January 1, 2027 to CMS approvals of section 1115 Medicaid demonstration project applications, renewals, or amendments. CMS issued state Medicaid Director Letter #26-003² on June 11, 2026 to provide states with early notice regarding the changes to budget neutrality that CMS intends to propose to implement section 1115(g) of the Act and expects to provide additional guidance to states on implementation of this provision.

Under SMDL #24-003, as a condition of demonstration approval, demonstrations must be “budget neutral,” meaning the federal costs of the state’s Medicaid program with the demonstration cannot exceed what the federal government’s Medicaid costs likely would have been in that state absent the demonstration.³ The demonstration renewal is projected to be budget neutral to the federal government. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the “without waiver” costs).

The Continuity of Care and Administrative Simplification demonstration is not expected to impact the overall number of people enrolled in the Medicaid program or increase expenditures beyond what those expenditures likely would have been without the demonstration. The Continuity of Care and Administrative Simplification demonstration does not change the eligible populations, rather it allows for the state to keep people in their managed care plans and to continue not implementing HPE. Therefore, this is not expected to have an appreciable financial impact.

Monitoring and Evaluation

Consistent with the demonstration STCs, the state submitted with the renewal application its Interim Evaluation Report for the prior demonstration approval period, which was approved for the period from January 19, 2021 through December 31, 2025. Based on available data in the

¹ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf>

² <https://www.medicaid.gov/federal-policy-guidance/downloads/smd26003.pdf>

³ <https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality/index.html>

state's Interim Evaluation Report, which includes the time period of January 1, 2016 through December 31, 2023, CMS determined that the state has been making progress towards the demonstration goals.

Specifically, the state demonstrated improved coverage continuity and temporary improvement in reducing administrative burden. For example, the percentage of MCO enrollees experiencing coverage gaps declined by 0.9 percentage points, re-enrollment in the same MCO after recertification failure increased by 56 percentage points, the churn between MCO and fee-for-service declined 15 percentage points, and Medicaid applications exceeding 45 days for processing declined by 98 percent through 2021.

However, the attribution of the improvement to the demonstration is limited due to the overlapping of the COVID-19 Public Health Emergency continuous enrollment provision. The state reported mixed or limited support for improvements in care coordination, continuity of care, quality of care, health outcomes, and overall MCO enrollment. For example, cervical cancer screening decreased by 7 percentage points from pre-pandemic, and emergency department utilization remained largely unchanged. In addition, MCO enrollment declined by 13 percentage points.

Based on the mixed progress made thus far on its goals, the state is requesting, and CMS is granting additional time to continue its demonstration. To ensure transparency towards continued progress on more of the demonstration goals and to address the identified areas for improvement, the state is required under this renewal to continue conducting systematic monitoring and robust evaluation of the demonstration. In collaboration with CMS, the state must undertake demonstration monitoring, including reporting of relevant metrics data and narrative details describing progress with implementation of all components of the demonstration.

The state is required to conduct an evaluation of the demonstration which includes the temporary extension approval period that ran from January 1, 2026 through September 29, 2026. The evaluation supports a comprehensive assessment of whether the demonstration components are effective in producing the desired outcomes for its beneficiaries and providers, as well as the state's overall Medicaid program. The demonstration evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components, as described in the STCs.

Consideration of Public Comments

The federal public comment period for the state's renewal application opened on July 16, 2025, and closed on August 15, 2025. A total of three comments were received. All three commenters supported the proposal to continue to allow automatic re-enrollment into the enrollee's prior MCO. Two commenters opposed continuing to allow the state to delay HPE implementation because they said it would keep the state from providing temporary, on-the-spot Medicaid eligibility determinations by hospitals for individuals who appear to qualify for Medicaid. According to these commenters, people often are unaware they are Medicaid-eligible until a medical event occurs. By providing HPE, states can make sure patients can access critical care without facing financial barriers or medical debt. People who are Medicaid-eligible might delay treatment because of costs if they are not able to access immediate eligibility through HPE.

CMS acknowledges the commenters' concerns and with this approval, the state will become compliant by January 1, 2029.

After carefully reviewing the public comments submitted during the federal comment period, CMS has concluded that renewing the Illinois Continuity of Care and Administrative Simplification demonstration is likely to assist in promoting the objectives of Medicaid.

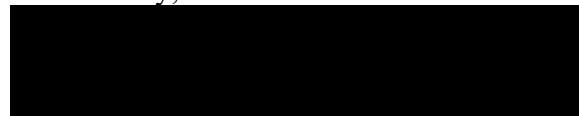
Other Information

CMS's approval of this demonstration renewal is conditioned upon compliance with the enclosed waiver and expenditure authorities and the STCs defining the nature, character, and extent of anticipated federal involvement in the demonstration. The award is subject to our receiving your acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter. Your project officer, Michael Trieger, is available to answer any questions concerning this demonstration renewal, and his contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Michael.Trieger1@cms.hhs.gov

If you have questions regarding this approval, please contact Sarah Aker, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at Sarah.Aker@cms.hhs.gov.

Sincerely,



Dan Brillman
Deputy Administrator, CMS
Director, Center for Medicaid and CHIP Services

Enclosure

cc: Courtenay Savage, State Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: 11-W-00341/5

TITLE: Illinois Continuity of Care and Administrative Simplification

AWARDEE Department of Healthcare and Family Services (HFS)

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project October 1, 2026 through September 30, 2031. In addition, this waiver may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of the Section 1115(a)(1) of the Social Security Act (“the Act”), the following waiver is granted to enable Illinois (referred to herein as the state) to operate the Continuity of Care and Administrative Simplification demonstration. This waiver is effective beginning October 1, 2026 and will end on December 31, 2028, and is limited to the extent necessary to achieve the objectives below. This waiver may only be implemented consistent with the approved STCs set forth in the accompanying document.

1. Hospital Presumptive Eligibility (HPE)

1902(a)(47)(B)

To the extent necessary, to enable the state not to implement a hospital presumptive eligibility program for individuals through December 31, 2028. The state will continue to operate Medicaid presumptive eligibility for children and pregnant women under the Medicaid state plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: 11-W-00341/5

TITLE: Illinois Continuity of Care and Administrative Simplification

AWARDEE Department of Healthcare and Family Services (HFS)

Under the authority of section 1115(a)(2) of the Social Security Act (“the Act”), expenditures made by Illinois for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from October 1, 2026 through September 30, 2031, unless otherwise specified, be regarded as expenditures under the state’s title XIX plan. All requirements of the Medicaid statute not explicitly identified as not applicable will be applicable to such expenditure authorities.

The Secretary of Health and Human Services has determined that the Illinois Continuity of Care and Administrative Simplification section 1115 demonstration, including the granting of the expenditure authority described below, is likely to assist in promoting the objectives of title XIX of the Act.

The following expenditure authority may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable Illinois to operate this section 1115(a) demonstration.

1. Demonstration Operations for Automatic Reenrollment into the Managed Care

Organization (MCO). Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Illinois managed care plans will be required to meet all requirements of section 1903(m) of the Act except the following:

- a. Section 1903(m)(2)(H), along with 42 CFR 438.56(g), to allow automatic re-enrollment into the enrollee’s prior managed care organization when a Medicaid beneficiary loses Medicaid eligibility due to failure to complete the renewal process and is redetermined eligible, without a new application, if he/she submits redetermination paperwork documentation within 90 days after termination. This expenditure authority does not impact the requirements under 42 CFR 438.56(c)(2)(iii), which allows a beneficiary to request disenrollment if a temporary loss of eligibility caused the beneficiary to miss the annual disenrollment opportunity.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00341/5

TITLE: Illinois Continuity of Care and Administrative Simplification

AWARDEE Department of Healthcare and Family Services (HFS)

1. PREFACE

The following are the Special Terms and Conditions (STCs) for the Illinois Continuity of Care and Administrative Simplification section 1115(a) Medicaid demonstration (hereinafter “demonstration”), to enable the Illinois Department of Healthcare and Family Services (HFS) (hereinafter “state”) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted a waiver of requirements under section 1902(a) of the Social Security Act (“the Act”), and an expenditure authority authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waiver and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS related to the demonstration. These STCs neither grant additional waivers nor expenditure authorities, nor expand upon those separately granted.

The STCs related to the programs for those populations affected by the demonstration are effective from October 1, 2026 through September 30, 2031, unless otherwise specified.

The STCs have been arranged into the following subject areas:

1	Preface
2	Program Description and Objectives
3	General Program Requirements
4	Eligibility and Enrollment
5	Demonstration Program and Benefits
6	Cost Sharing
7	Delivery System
8	Monitoring and Reporting Requirements
9	Evaluation of the Demonstration
10	General Financial Requirements
11	Schedule of Deliverables

An additional attachment has been included to provide supplementary information and guidance for specific STCs.

Attachment A	Evaluation Design (Reserved)
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2. PROGRAM DESCRIPTION AND OBJECTIVES

In this demonstration, the state will have the authority to allow beneficiaries whose coverage was terminated for failure to complete the renewal process to automatically reenroll into their prior Medicaid managed care organization (MCO) without requiring a new application if the individual subsequently returns their redetermination paperwork within 90 days of their date of termination as well as the authority to waive hospital presumptive eligibility (HPE) requirements through December 31, 2028.

During the demonstration period, the state seeks to continue to achieve the following goals:

- Assisting Illinois in ensuring continuity of care for beneficiaries whose coverage was terminated for failure to return their renewal form or other required information at renewal by automatically enrolling them in the same managed care plan they were previously enrolled in as long as the beneficiary submits their Medicaid redetermination paperwork within 90 days from the date of termination;
- Allowing the state a limited time to enable the state to implement changes from the Working Families Tax Cut (WFTC) legislation and make sure it is properly prepared for the implementation of HPE, allowing the state to engage stakeholders in the development of HPE policies and establishing hospital performance standards.

3. GENERAL PROGRAM REQUIREMENTS

- 3.1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).
- 3.2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
- 3.3. **Changes in Medicaid and CHIP Law, Regulations, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
- 3.4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP;
 - b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.
- 3.5. **State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendment for changes affecting any populations made eligible solely through the demonstration.

If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

- 3.6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.
- 3.7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:
- a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
 - b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
 - c. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
 - d. An up-to-date CHIP allotment worksheet, if necessary;

- e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and monitoring reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 Code of Federal Regulations (CFR) §431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 3.9.

3.9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

- a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan;
- b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available;
- c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan;
- d. Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(d)(1). For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply

with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable advance notice requirements and fair hearing rights described at 42 CFR 431, Subpart E. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230;

- e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g);
- f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan;
- g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

3.11. **Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 3.7 or extension, are proposed by the state.

- 3.13. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.
- 3.14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.
- 3.15. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

4. ELIGIBILITY AND ENROLLMENT

- 4.1. **Eligibility Groups Affected by the Demonstration.** Under the demonstration, there is no change to Medicaid eligibility and the standards and methodologies for eligibility remain set forth under the state plan.
- 4.2. **Waiver of Hospital Presumptive Eligibility.** This demonstration provides a waiver of the HPE requirement under section 1902(a)(47)(B) to promote continuity of care by encouraging timely submission of full benefit Medicaid applications, and reducing processing times. The waiver expires on December 31, 2028.

5. DEMONSTRATION PROGRAM AND BENEFITS

- 5.1. This demonstration does not change the Medicaid benefit package design. State plan benefits continue to be applied in accordance with the state plan.

6. COST SHARING

- 6.1. **Cost Sharing.** Cost sharing imposed upon individuals enrolled in the demonstration is consistent with the provisions of the approved state plan.

7. DELIVERY SYSTEM

- 7.1. **Delivery System.** The demonstration delivery system does not differ from the Medicaid plan, except as discussed below.
- 7.2. **Managed Care Reinstatement when a Medicaid Beneficiary Submits Late Paperwork within 90 Days.** The demonstration allows the state to reinstate a beneficiary into their previous managed care plan if the beneficiary submits his/her Medicaid redetermination paperwork within 90 days of a loss in Medicaid eligibility.

8. MONITORING AND REPORTING REQUIREMENTS

- 8.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of \$5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs, hereafter singly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

- a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s);
- b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps the state has taken to address such issue, and the state’s anticipated date of submission. Should CMS agree in writing to the state’s request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if corrective action is proposed in the state’s written extension request;

- c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state;
- d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) is/are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released;

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

- 8.2. **Submission of Post-approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs, unless CMS and the state mutually agree to another timeline.
- 8.3. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:
 - a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
 - b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
 - c. Submit deliverables to the appropriate system as directed by CMS.
- 8.4. **Monitoring Reports.** The state must submit one Annual Monitoring Report each demonstration year (DY) that is due no later than 180 calendar days following the end of the DY. The state must submit a revised Annual Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. CMS will make on-going determinations about reporting frequency under the demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid (See 42 CFR 431.420(d)(1)-(2)).

The Annual Monitoring Report will include all required elements as per 42 CFR 431.428, and

should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Annual Monitoring Report must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve and must be provided in a structured manner that supports federal tracking and analysis.

- a. **Operational Updates.** Per 42 CFR 431.428(a)(1), the Annual Monitoring Report must document any policy or administrative difficulties in operating the demonstration. The Annual Monitoring Report must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Annual Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration;
- b. **Performance Metrics.** The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration's goals and any applicable milestones. Per 42 CFR 431.428(a), the Annual Monitoring Report must document the impact of the demonstration on beneficiaries' outcomes of care, quality and overall cost of care, and access to care, as applicable. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals. The Annual Monitoring Report must provide detailed information about deviations from CMS's applicable metrics technical specifications, relevant methodology, plans for phasing in metrics, and data or reporting issues for applicable metrics, in alignment with CMS guidance and technical assistance.

The state and CMS will work collaboratively to finalize the list of metrics to be reported in the Annual Monitoring Report. The demonstration's monitoring metrics must cover categories to include, but not be limited to, eligibility, utilization of services, quality of care and health outcomes, and grievances and appeals. The state must report these metrics for all demonstration populations. Demonstration monitoring reporting does not duplicate or replace reporting requirements for other authorities, such as Home and Community Based Services and Managed Care authorities.

The reporting of these monitoring metrics may also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography) and by demonstration component, as appropriate. Subpopulation reporting can support identifying any gaps in quality of care and health outcomes, and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population;

- c. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Annual Monitoring Reports must document any results of the demonstration to date per the evaluation

hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

- 8.5. **Corrective Action Plan Related to Demonstration Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS might withdraw an authority, as described in STC 3.10, if metrics indicate substantial and sustained directional change inconsistent with state's demonstration goals and desired directionality, and the state has not implemented corrective action, and the circumstances described in STC 3.10 are met. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.
- 8.6. **Close-Out Report.** Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.
- a. The Close-Out Report must comply with the most current guidance from CMS;
 - b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 9.7 and 9.8, respectively;
 - c. The state will present to and participate in a discussion with CMS on the Close-Out Report;
 - d. The state must take into consideration CMS' comments for incorporation into the final Close-Out Report;
 - e. The revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments;
 - f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 8.1.
- 8.7. **Monitoring Calls.** CMS will convene, no less frequently than quarterly, monitoring calls with the state.

- a. The purpose of these calls is to discuss ongoing demonstration operations and implementation which align with the state's demonstration monitoring reports, including (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, eligibility and access, and progress on evaluation activities;
 - b. These calls will follow the structure of and focus on the topics in the Annual Monitoring Report;
 - c. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration;
 - d. The state and CMS will jointly develop the agenda for the calls.
- 8.8. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent Annual Monitoring Report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the year in which the forum was held.

9. EVALUATION OF THE DEMONSTRATION

- 9.1. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f). This may also include the state's participation — including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable — in a federal learning collaborative aimed at cross state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring, and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 8.1.

- 9.2. **Independent Evaluator.** The state must use an independent entity (herein referred to as the Independent Evaluator) to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accord with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.
- 9.3. **Evaluation Design.** The state must submit, for CMS comment and approval, an Evaluation Design no later than 180 calendar days after the approval of the demonstration. However, additional time may be allotted for this submission with CMS approval. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The Evaluation Design must be developed in accordance with the STCs and any applicable CMS guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations.

The state is strongly encouraged to use the expertise of the Independent Evaluation in the development of the Evaluation Design. The Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STC 9.7 and 9.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component, unless otherwise agreed upon by the state and CMS. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. The amendment components of the Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

- 9.4. **Evaluation Design Approval and Updates.** The state must submit a revised Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the Evaluation Design, the documents will be posted to Medicaid.gov. Per 42 CFR 431.424(c), and the state will publish the approved Evaluation Design within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each Annual Monitoring Report. Once CMS approves the Evaluation Design, if the state wishes to make changes and the changes are substantial in scope, the state must submit a revised Evaluation Design to CMS for approval; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in Annual Monitoring Reports.
- 9.5. **Evaluation Questions and Hypotheses.** Consistent with STCs and applicable CMS guidance, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical

assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as eligibility and various measures of access, utilization, costs, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance for the demonstration policy components. The evaluation is expected to use applicable demonstration monitoring and other data on the provision of and beneficiary utilization of demonstration and other applicable services. Proposed measures should be selected from nationally recognized sources and national measures sets, where possible. Measures sets could include the Consumer Assessment of Health Care Providers and Systems, the Medicaid and CHIP Core Sets of Health Care Quality measures, commonly referred to as the Child and Adult Core Sets, the Behavioral Risk Factor Surveillance System survey, or measures endorsed by National Quality Forum.

The state must develop robust evaluation questions and hypotheses related to each demonstration initiative, and per applicable CMS guidance. Hypotheses for waiver of hospital presumptive eligibility must relate to enrollment and enrollment continuity, and hypotheses for re-enrollment into a prior managed care plan must relate to continuity of coverage and care, and health outcomes.

As part of its evaluation efforts, the state must also conduct an overall demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation and Medicaid health services expenditures. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey or interviews to assess, for instance, beneficiary understanding of the demonstration policy components and beneficiary experiences with access to and quality of care. To better understand whether implementing certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—and barriers to—implementation, the state is strongly encouraged to undertake a robust process/implementation evaluation. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state may collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography). Such stratified data analyses can provide a fuller understanding of gaps in access to and quality of care and health outcomes, and help inform how the demonstration's various policies support improving outcomes.

- 9.6. Evaluation Budget.** A budget for the evaluations must be provided with the Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative

and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

9.7. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). The draft Interim Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

- a. The Interim Evaluation Reports will discuss evaluation progress and present findings to date as per the approved Evaluation Design;
- b. For demonstration authority or any component within the demonstration that expires prior to the overall demonstration's expiration date, and depending on the timeline of the expiration/phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state;
- c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted, or in one year prior to the end of the demonstration, whichever is sooner. When applying for an extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment. If the state does not request an extension for the demonstration, the Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension;
- d. The state must submit a revised Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report, if any;
- e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

9.8. Summative Evaluation Report. The state must submit the draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

- a. The state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft Summative Evaluation Report, if any;

- b. Once approved by CMS, the state must post the final Summative Evaluation Report on the state's Medicaid website within 30 calendar days.

- 9.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.
- 9.10. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, or the Summative Evaluation Report.
- 9.11. **Public Access.** The state shall post the final documents (e.g., Annual Monitoring Report, Close-Out Report, Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.
- 9.12. **Additional Publications and Presentations.** For a period of twelve months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

10. GENERAL FINANCIAL REQUIREMENTS

- 10.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.
- 10.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the MBES/CBES to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the

State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state and include the reconciling adjustment in the finalization of the grant award to the state.

- 10.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms, and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.
- a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration;
 - b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS;
 - c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.
- 10.4. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:
- a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations;

- b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. Consistent with 42 CFR 433.51(c), the federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law;
- c. The state may use intergovernmental transfers to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration;
- d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment;
- e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

10.5. Financial Integrity for Managed Care and Other Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

- a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments comply with the requirements on payments in 42 CFR 438;
- b. For non-risk-based PIHPs and PAHPs, arrangements comply with the upper payment limits specified in 42 CFR 447.362, and if payments exceed the cost of services, the state will recoup the excess and return the federal share of the excess to CMS.

- 10.6. **Requirements for health care related taxes and provider donations.** As a condition of demonstration approval, the state attests to the following, as applicable:
- a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c);
 - b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d);
 - c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72;
 - d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f);
 - e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.
- 10.7. **Additional State Attestations.** The state further attests that all provider-related donations and health care-related taxes are compliant with the applicable federal requirements, including bona fide status and absence of hold harmless arrangements as defined by relevant sections of the Social Security Act and Code of Federal Regulations.
- 10.8. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 8.1. This report must include:
- a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;
 - b. Number of providers in each locality of the taxing entities for each locality tax;
 - c. Whether or not all providers in the locality will be paying the assessment for each locality tax;
 - d. The assessment rate that the providers will be paying for each locality tax;
 - e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

- f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;
- g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and
- h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

10.9. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures.

- a. Administrative costs, including those associated with the administration of the demonstration;
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
- c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

10.10. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

10.11. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEGs) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 1: Master MEG Chart

MEG	Which BN Test Applies?	Without Waiver (WOW) Per Capita	WOW Aggregate	With Waiver (WW)	Brief Description
ADM	N/A	N/A	N/A	N/A	All additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality.

- 10.12. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00341/5). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. The state also must report member months of eligibility for specified MEGs.
- a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c) or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported;
 - b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits;
 - c. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the Master MEG Charts and in the STCs in Section 11, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS;
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Table 2: MEG Detail for Expenditure Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expenditures Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG end Date
ADM	N/A	N/A	N/A	N/A	N/A	N/A	1/1/2021	9/30/31

10.13. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

Table 3: Demonstration Years

Demonstration Year	Start Date	End Date
DY 7	October 1, 2026	September 30, 2027
DY 8	October 1, 2027	September 30, 2028
DY 9	October 1, 2028	September 30, 2029
DY 10	October 1, 2029	September 30, 2030
DY 11	October 1, 2030	September 30, 2031

10.14. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

10.15. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:

- a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider

donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable;

- b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law;
- c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

11. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Deliverable	Timeline	STC Reference
State acceptance of demonstration waiver, expenditure authority, and STCs	30 calendar days after approval date	Approval letter
Evaluation Design	No later than 180 calendar days after approval of the demonstration. Revised no later than 60 days after receipt of CMS comments.	STC 9.3 and 9.4
Interim Evaluation Report	One year prior to the end of the demonstration period, or when the extension application is submitted, whichever is sooner. Revised no later than 60 calendar days after receipt of CMS comments.	STC 9.7
Summative Evaluation Report	No later than 18 months after the end of the demonstration period. Revised no later than 60 calendar days after receipt of CMS comments.	STC 9.8
Annual Monitoring Reports	No later than 180 calendar days after the end of each demonstration year.	STC 8.4

Attachment A
Evaluation Design (Reserved)